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A practical approach to the assessment of psychosocial and psychiatric comorbidity in the dermatology patient

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Abstract It is well recognized that the clinical course of many dermatologic disorders is the result of a complex and sometimes reciprocal interaction between biological, psychiatric/psychological, and social factors that can have a predisposing, precipitating, and/or perpetuating role for the dermatologic disorder. Assessment of psychiatric and psychosocial comorbidity, which can be present in up to 30% of dermatology patients, is an important component of the overall clinical evaluation of the patient. This paper discusses a practical approach to the assessment of psychosocial and psychiatric factors, including suicide risk and parasuicidal behaviors in the dermatology patient. The approach further classifies these factors as predisposing, precipitating, and/or perpetuating, in order to aid the clinician with the possible secondary and tertiary prevention of some dermatologic disorders by management of their psychosocial and psychiatric comorbidity.

Introduction

Assessment of psychiatric and psychosocial comorbidity, which is present in up to 30% of dermatology patients, is an important component of the overall clinical evaluation of the patient.[1,2] It is well recognized that the clinical course of a range of dermatologic disorders is the result of a complex and sometimes reciprocal interaction between biological, psychiatric/psychological, and social factors that can play a predisposing, precipitating, and/or perpetuating role for the dermatologic disorder. This paper discusses an approach to the assessment of psychosocial and psychiatric factors in the dermatology patient, and classifies these factors as predisposing, precipitating, and/or perpetuating factors, in order to aid the clinician with the possible secondary and tertiary prevention of some dermatologic disorders by management of their psychosocial and psychiatric comorbidity.

Psychosocial factors

It is important to assess psychosocial factors, such as stress associated with having to cope with a chronic and disfiguring skin condition, stressful life events, and

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Table 1 Psychosocial stressors and the stress-reactive dermatologic disorders

Psychosocial stressor	Predisposing factors	Precipitating factors	Perpetuating factors
Dermatologic disease–related stress, ie, stress and daily hassles from impact of skin disorder on the quality of life. Children and adolescents may experience bullying. Important factor in cosmetically disfiguring disorders.		Onset/exacerbation of stress-reactive dermatoses that tend to be cosmetically disfiguring eg, acne, psoriasis, atopic dermatitis.	Stress and hassles from having to live with a chronic and usually cosmetically disfiguring dermatologic condition can be a perpetuating factor.
Major stressful life events, eg, loss of job, marital stress, death of spouse.		Onset/exacerbation of a wide range of stress-reactive dermatoses.	Unresolved stressors may lead to perpetuation of dermatologic disorder.
Traumatic life events, ie, events that overwhelm the patient's coping capacity, eg, history of severe neglect, sexual abuse, and trauma of war. May affect patient years after the initial event, as patients may get triggered by a person or event that reminds them of the trauma. May be associated with autonomic nervous system (ANS) dysregulation.	ANS dysregulation and hyperarousal may predispose to exacerbations stress-reactive and self-induced dermatoses.	Onset/exacerbation of a wide range of stress-reactive dermatoses, especially disorders associated with autonomic hyperarousal, eg, urticaria. May precipitate self- induced dermatoses.	Perpetuation of a wide range of stress-reactive dermatoses, especially disorders associated with autonomic hyperarousal. Factor in chronic idiopathic urticaria and chronic self-induced dermatoses, eg, acne excoriée, dermatitis artefacta.

Table 2 A practical approach to the assessment and initial management of psychosocial stressors in the dermatology patient

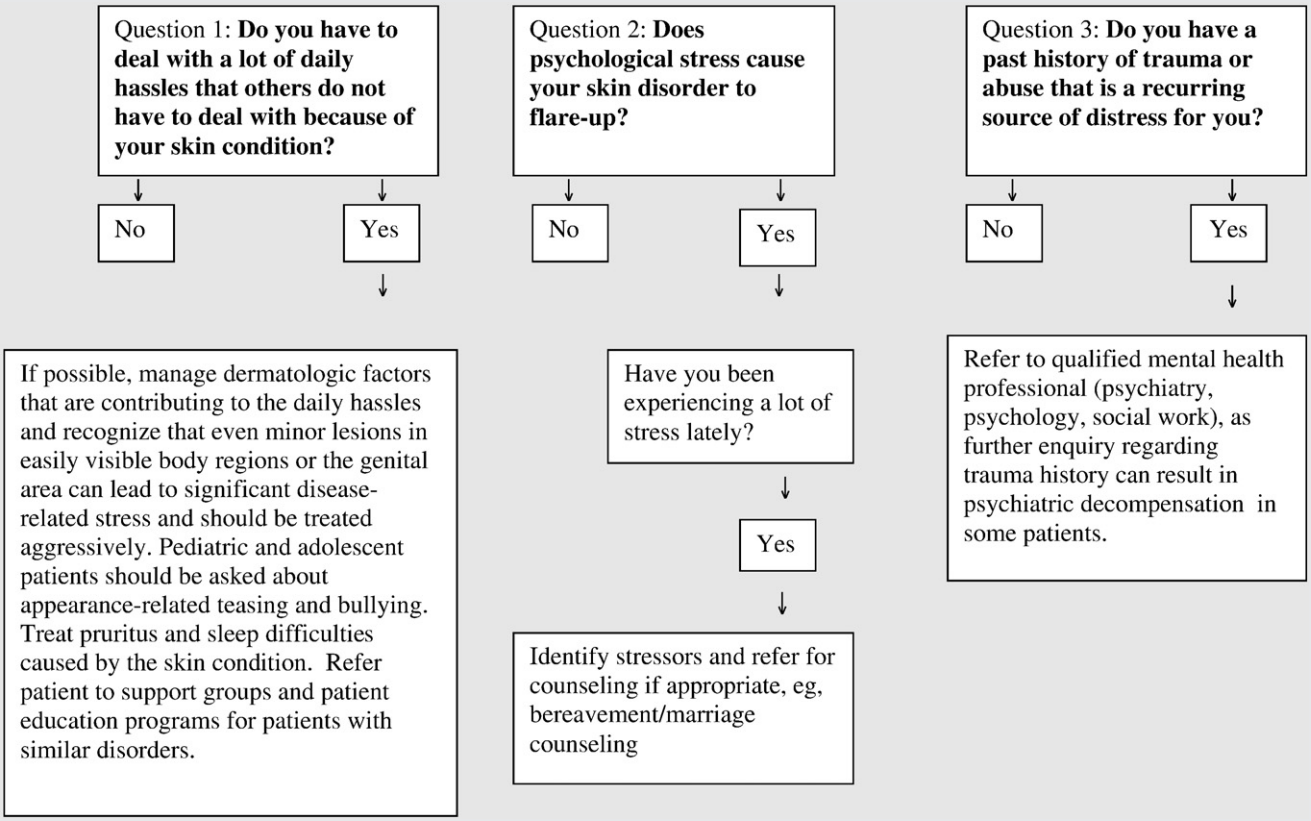

Table 3 Psychiatric pathology that can present as a dermatologic symptom[3]

1. **Delusions**
   Delusional parasitosis, folie à deux
   Delusional bromhidrosis (delusional belief that a foul odor is being emitted)
   Delusions of disfigurement
2. **Hallucinations/distortion of other perceptual modalities**
   Tactile or haptic hallucinations
   Amplified or dysesthetic cutaneous pain
3. **Conversion and dissociation**
   Unexplained sensory syndromes (eg, cutaneous pain, numbness, pruritus), "psychogenic purpura"
   Idiopathic urticaria and angioedema
   Self-induced dermatoses (eg, acne excoriée, dermatitis artefacta, trichotillomania, onychophagia)
4. **Depression**
   Poor body image, out of proportion to objective dermatologic findings
   Cutaneous dysesthesias, eg, "burning scalp," glossodynia can be "depressive equivalents"
   Concern about clinical severity of skin lesion, eg, concern about malignancy that is grossly out of proportion to objective clinical dermatologic findings
   Lack of self-care, leading to poor adherence to dermatologic therapies and poor personal hygiene
5. **Hypomania/Mania**
   Hyperinflated body image
   Excessive spending on cosmetic dermatologic treatments and procedures
6. **Obsessions and compulsions**
   Compulsive hand washing, compulsive rubbing or picking of the skin or self-excoriation
   Trichotillomania
   Onychophagia and onychotillomania
7. **Anxiety and panic**
   Unexplained profuse perspiration, night sweats
   Flushing reactions
   Idiopathic urticaria
8. **Body image distortion related to the skin**
   Dermatological complaints about imagined or slight "flaws" or aging of skin

psychological trauma (Table 1), as psychosocial stress has been shown to have a direct impact on skin barrier function and a wide range of immune parameters that can directly affect the skin condition.[3] There are a wide range of both disease-specific and general dermatology quality-of-life scales, scales that assess stress secondary to major life events and scales for measuring the impact of traumatic life events, that are useful tools in research settings, but typically are too detailed and not practical for use in a clinical dermatology setting. Table 1 summarizes the major types of psychosocial stressors that are important in the onset and/or exacerbation of stress-reactive dermatologic disorders. Traumatic life events that are sometimes associated with autonomic nervous system dysregulation and sympathetic hyperarousal, may play a predisposing, precipitating, and perpetuating role in the stress-reactive dermatoses, such as psoriasis, atopic dermatitis, and idiopathic urticaria, and also in the pathogenesis of the self-induced dermatoses, where patients may excessively manipulate their integument, eg, in trichotillomania, acne excoriée, and dermatitis artefacta, in order to regulate their emotions. Table 2 provides a practical guideline for the initial assessment of psychosocial stressors in the dermatology patient that can be used in a busy clinic setting.

Psychiatric pathology

Table 3 summarizes some dermatologic symptoms[1-3] that represent primary psychiatric pathology and are encountered in a wide range of psychiatric disorders.[4] Table 4 summarizes the clinical aspects of some of the major psychiatric disorders[4] that may be encountered in the dermatology patient. Table 5 provides some general clinical guidelines for the assessment and management of suicide risk and parasuicidal behaviors, ie, intentional self-injury without the intent of dying, that may be encountered in patients with self-induced dermatoses.[5,6]

Table 4 Some psychiatric disorders (DSM-IV-TR)[4] encountered in the dermatology patient

Major Depressive Disorder (MDD): Characterized by major depressive episodes (ie, ≥2 week of at least one of depressed mood or loss of interest or pleasure), accompanied by ≥4 of the following symptoms of depression that represent a change from previous functioning: psychomotor agitation or retardation, decrease or increase in appetite, insomnia or hypersomnia nearly every day, fatigue or loss of energy, feelings of worthlessness or excessive or inappropriate guilt, indecisiveness or decreased concentrating ability, and recurrent thoughts of death with or without suicidal ideation. May be a precipitating factor (eg, MDD may decrease pruritus threshold), mainly a perpetuating factor (eg, insomnia in MDD may complicate course of pruritus, decreased adherence/response to dermatologic therapies).

Obsessive-compulsive Disorder (OCD): Recurrent obsessions or compulsions severe enough to cause marked distress or significant impairment. Obsessions are recurrent and persistent thoughts, impulses, or images that are experienced as intrusive and inappropriate, that cause marked anxiety or distress, and that cannot be eliminated from consciousness by logical effort. Compulsions are repetitive behaviors such as hand washing, hair plucking, picking of the skin or lesions on the skin, bathing or checking, or mental acts such as counting that the person feels driven to perform in response to an obsession and that, if resisted, produces anxiety. May be a precipitating factor (eg, self-induced dermatoses), mainly a perpetuating factor (eg, self-induced dermatoses, Koebner phenomenon).

Social Phobia (Social Anxiety Disorder): Characterized by clinically significant anxiety, sometimes manifesting as a panic attack, provoked by exposure to certain types of social or performance situations in which embarrassment may occur, often leading to avoidance behavior. May be precipitating factor (eg, patients with hyperhidrosis or rosacea who perspire or blush more prominently in embarrassing situations may experience exacerbation of their symptoms; patients with dermatoses that are stress reactive, eg, psoriasis and atopic dermatitis, may experience heightened anxiety and stress and possible exacerbation of their skin disorder when feeling self-conscious about their skin condition) or perpetuating factor for stress-reactive dermatoses.

Posttraumatic Stress Disorder (PTSD): Essential feature of PTSD involves exposure to traumatic event where the person experienced or was confronted with events that involved actual or threatened death or serious physical or emotional injury. Patients may present with symptoms of increased arousal, which can manifest as hypervigilance, an exaggerated startle response, irritability, sleep difficulties or somatic reactions associated with increased sympathetic activity including idiopathic urticaria. During states of hyperarousal patients may experience numbness, waves of unexplained pruritus, and the self-induced dermatoses, eg, dermatitis artefacta or trichotillomania. The traumatic event is re-experienced as recurrent dreams, recurrent and intrusive images, thoughts or perceptions including cutaneous hallucinations, and dissociative flashback that may include "body memories" of the trauma, eg, development of urticarial wheal where patient had been beaten. Most dermatology patients have PTSD that is **chronic** (symptoms ≥3 months) and **with delayed onset** (onset of symptoms at least 6 months after stressor), and in relation to childhood neglect and abuse. PTSD can be a precipitating factor (self-induced dermatoses; stress reactive dermatoses, eg, psoriasis, atopic dermatitis, idiopathic urticaria) and more commonly a perpetuating factor for these conditions as a result of the state of hyperarousal and autonomic dysregulation that is associated with PTSD.

Body Dysmorphic Disorder (BDD): Presents as a preoccupation with an imagined defect in appearance; or if a slight anomaly is present the individual's concern is excessive; also referred to as dysmorphophobia. Complaints commonly involve imagined or slight flaws of the face or head such as thinning hair, acne, wrinkles, scars, vascular markings, paleness or redness of the complexion, swelling, facial disproportion or asymmetry, or excessive facial hair. Some associated features include excessive grooming behavior such as excessive hair combing, hair removal, hair picking, or ritualized make-up application. Most individuals experience marked distress over their supposed deformity and feelings of self-consciousness over their "defect," which often leads to vocational and social impairment. May be predisposing or precipitating factor (eg, acne excoriée), mainly perpetuating factor (eg, self-induced dermatoses, Koebner phenomenon).

Dissociative Amnesia: Presents as an inability to recall important personal information, usually of a traumatic or stressful nature, and the amnesia is too extensive to be explained by ordinary forgetfulness. Dissociative amnesia can be associated with PTSD. Patients most commonly present with a retrospectively reported gap or series of gaps in recall for aspects of their life history that are usually related to extremely stressful or traumatic events. Often both precipitating and perpetuating factors for dermatitis artefacta, where patients may self-inflict severe injury and deny a history of self-inflicting the lesions, and other self-induced dermatoses such as trichotillomania, neurotic excoriations, acne excoriée.

Table 5 Assessment of suicide risk and parasuicidal behaviors[2,5,6] in the dermatology patient

Assessment of the suicidal patient

In this table, suicide refers to all 3 stages, ie, suicidal ideation, suicide attempts, and completed suicide. No combination of risk factors has adequate specificity or sensitivity to select patients with suicidal ideation who go on to attempt suicide.[5] Overall incidence of completed suicide in the United States is 11 per 100,000. Suicide is the third leading cause of death in the 18- to 24-year age group.[6]

Dermatologic factors: 50% of patients who attempt suicide have a physical illness, especially chronic disease and chronic pain. Severe pruritus, especially when associated with sleep disruption, and cosmetically disfiguring skin conditions, have been associated with a higher frequency of suicidal thoughts and cases of completed suicide.[2] Among adolescent acne patients, factors such as bullying and even clinically mild disease have been associated with suicide.

Demographics: Suicide rate rises rapidly among adolescent and young adults ages 16 to 24 years, plateaus in middle age, then rises again with peak incidence among men at age 75 years and women 55-65 years.[5,6] Women attempt suicide 3 to 4 times more frequently than men; men are 2 to 3 times more likely to be successful in committing suicide. In the US, suicide is more common among whites; the unemployed; single, separated, divorced, and widowed with loss of a spouse increasing suicide risk for at least 4 years after spousal death.[6]

Psychiatric factors: Up to 90% of patients who commit suicide may have a psychiatric disorder (50% Major Depressive Disorder; 25% Substance Abuse and Dependence; psychotic disorders, such as Schizophrenia; Posttraumatic Stress Disorder; and Body Dysmorphic Disorder).

History[2,5]: Suicidal patients are typically relieved to be asked about suicide; asking patients about suicide does not put the idea into their heads. Offer the patient a private setting when enquiring about suicide and carefully document the clinical assessment. Suicide usually has legal implications. It is appropriate to ask a question like: "Have you had thoughts about killing yourself?" and "Have things been so bad that you have had thoughts of hurting yourself or ending your life?" Enquire about suicidal thoughts, suicidal plans, whether the planned means are available to the patient, and the degree to which the patient intends to act on his or her suicidal thoughts and plans. Access to lethal means is a risk factor for suicide. Patients with a *prior history of suicide attempts and threats* have a 5- to 6-fold increased risk of trying again. Even apparently manipulative and chronic patients who make repeated threats eventually succeed in killing themselves, therefore *all threats should be taken seriously* and managed as a psychiatric emergency; 25% to 50% of completed suicide victims have a history of previous suicide attempts. It is important not to try to talk the patient out of their suicidality, as premature or inappropriate reassurances may be misperceived by patients as a lack of permission to speak about their suicidal thoughts or lack of empathy on part of the clinician.

Management: If the clinician is unsure at any stage of assessment, an emergency psychiatric consultation should be sought. Acutely suicidal patients typically require emergency psychiatric hospitalization. Patients who are not imminently suicidal but have suicidal thoughts can be sent home with a definite follow-up plan after the clinician has ensured that the patient has an adequate support system at home, eg, by talking to the patient's family members after obtaining the patient's permission.

Assessment of the parasuicidal patient

Parasuicidal behavior is defined as intentional self-injury *without* the intention of dying. Behaviors that generally fit this definition are often encountered in dermatology, eg, in the patient with self-induced dermatoses, such as dermatitis artefacta, trichotillomania, acne excoriée, onychotillomania, and neurotic excoriations. When faced with a patient with self- induced dermatoses, the clinician should (1) *always assess the patient for suicide risk* and ensure that the patient is not suicidal. If suicide risk is suspected, treat the patient as suicidal. Use of methods with low potential lethality, eg, superficial abrasions of the skin and clearly sublethal drug overdoses, alone do not rule out suicidal intent; (2) be aware that although the self-induced skin lesion may not represent a suicidal act, the underlying psychiatric pathology that is leading the patient to self-induce the lesions, eg, BDD, PTSD, dissociative disorders (Table 4) may still place the patient at a high risk for suicide; (3) if unsure, refer the patient for emergency psychiatric consultation.

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